Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-361-2930

LHJ Use ID _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ID _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

Encephalitis, arboviral

County

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	Fever Highest measured temp: _____ °F Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Stiff neck
☐	☐	☐	☐	Eyes sensitive to light (photophobia)
☐	☐	☐	☐	Confusion
☐	☐	☐	☐	Tremors or hand shakes
☐	☐	☐	☐	Weakness
☐	☐	☐	☐	Muscle aches or pain (myalgia)
☐	☐	☐	☐	Seizures new with disease
☐	☐	☐	☐	Rash

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Viral encephalitis in past (e.g., dengue, SLE, yellow fever)
☐	☐	☐	☐	Neonatal Delivery location: _____
☐	☐	☐	☐	Pregnant Estimated delivery date ___/___/___ OB name, address, phone: _____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Abnormal neurologic findings**
☐	☐	☐	☐	**Altered mental status**
☐	☐	☐	☐	Cranial nerve abnormalities (bulbar weakness)
☐	☐	☐	☐	Movement disorder
☐	☐	☐	☐	Ataxia
☐	☐	☐	☐	Paralysis or weakness ☐ Acute flaccid paralysis ☐ Asymmetric ☐ Symmetric ☐ Ascending ☐ Descending
☐	☐	☐	☐	Rash observed by health care provider
☐	☐	☐	☐	Guillain-Barré syndrome
☐	☐	☐	☐	**Meningitis**
☐	☐	☐	☐	Meningoencephalitis

Clinical Findings (cont'd)

Y	N	DK	NA	
☐	☐	☐	☐	**Encephalitis or encephalomyelitis**
☐	☐	☐	☐	Coma
☐	☐	☐	☐	Complications, specify: _____
☐	☐	☐	☐	Admitted to intensive care unit

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Japanese encephalitis or yellow fever vaccine in past

Laboratory

Specimen type _____ Specimen type _____
Collection date ___/___/___ Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	CSF obtained Profile: wbc ____ (% lymph_____ % neutr____) rbc ____ prot ____ gluc ____
☐	☐	☐	☐	**[Probable case] virus-specific antibodies in serum (EIA)**
☐	☐	☐	☐	**Virus-specific immunoglobulin M (IgM) antibodies in CSF (EIA)**
☐	☐	☐	☐	**Fourfold or greater change between acute and convalescent serum antibody titers**
☐	☐	☐	☐	**Virus-specific IgM antibodies (by EIA) *and* IgG antibodies (by neutralization or hemagglutination inhibition)**
☐	☐	☐	☐	**Isolation of virus or demonstrated antigen by PCR (tissue, blood, CSF, or other body fluid)**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		onset
Days from onset:	-15	-2	
Calendar dates:			

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

☐ ☐ ☐ ☐ Case knows anyone else with similar symptoms

☐ ☐ ☐ ☐ Insect or tick bite
☐ Deer fly ☐ Flea ☐ Mosquito
☐ Tick ☐ Louse
☐ Other: _____
☐ Unknown insect or tick type
Location of insect or tick exposure: _____
_____
Date of exposure: ___/___/___

Y N DK NA

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

☐ ☐ ☐ ☐ Employed in laboratory

☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates)
Date of receipt: __/__/__

☐ ☐ ☐ ☐ Organ or tissue transplant recipient
Date of receipt:__/__/__

☐ ☐ ☐ ☐ If infant, birth mother had febrile illness

☐ ☐ ☐ ☐ If infant, confirmed infection in birth mother

☐ ☐ ☐ ☐ If infant, breast fed

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor)

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Breastfeeding education provided
☐ Notify blood or tissue bank
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____